



AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize LoginClinics, PLLC to disclose my individually identifiable health information as described below. I understand that this authorization is voluntary and I may refuse to sign this authorization. I further understand that my healthcare and the payment of my healthcare will not be affected if I do not sign.

I understand that the recipient authorized to receive the information is not a covered entity, e.g., insurance company or non-healthcare provider the released information may no longer be protected by federal and state privacy regulations.

I understand that this authorization will expire 180 days from the date of signature or at the date or the event specified here:

_____ (expiration date/event)

I further understand that I may revoke this authorization at any time, by notifying in writing, LoginClinics, PLLC at admin@loginclinics.com or by calling (919)679-1880. I understand that the revocation must be signed and dated with a date that is later than the date on this authorization. The revocation will not affect any releases made prior to the receipt of the written revocation.

Patient Name	Last Four of SSN	DOB	Account #	Medical Record #
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Street Address, City, State, Zip Code	Telephone #
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Please release this following information for these treatment dates: _____

The information will be released to: Patient/Designee Health Care Entity Insurance Co Attorney Other

Individual/Organization Name	Telephone #
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Street Address	City, State, Zip Code	Fax #
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Purpose of the use and/or disclosure: Continued Care Legal Use Personal Use Other _____

Record copy delivery: Pick Up Mail Fax

Information to be released: Medications Complete Chart Progress Notes Provider Orders Nursing Notes

I understand that the record might not be complete, if it is a recent visit, and additional documentation could be added after submitting this request.

Signature of Patient or Legal Representation

Date

Printed Name of Patient or Legal Representative

Relationship to Patient

Representative's Authority to Act for Patient